

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/29/2020
NAME OF PROVIDER OR SUPPLIER BLACKHAWK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of abbreviated complaint investigation #156053 for the above named facility conducted on 9/21,22,23,24,28,29/2020.	S 000		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 33 residents. Based on record review and interview the executive director failed to ensure the development of an initial negotiated service agreement for 2 (#3 and #9) of 7 sampled residents. Findings included: - Review of resident #3's medical record revealed he admitted to the facility on 7-30-20 with diagnoses of diabetes type 2, coronary artery disease, chronic kidney disease, alzheimers disease and chronic obstructive pulmonary disease. Review of the residents functional capacity screen (FCS) dated 8-27-20 revealed the resident required physical assistance with bathing, had bladder incontinence, current problems with falls,	S3090		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3090	Continued From page 1 wandering and impaired decision-making, and was unable to manage his own medications. Review of the negotiated service agreement (NSA) dated 8-27-20 revealed the facility staff would assist the resident with bathing twice a week, had generalized falls interventions, and identified staff would administer the residents medications 3-4 times per day. The NSA failed to identify services related to bladder incontinence, poor cognition, and wandering. Review of the resident's record lacked a initial negotiated service agreement dated on or before 7-30-20, the date of the resident's admission to the facility. - Review of resident #9's medical record revealed she admitted to the facility on 7-22-20 with diagnoses of anemia, repeated falls, coronary artery disease, reflux disease, dysphagia, and anxiety. Review of the resident's functional capacity screen dated 8-26-20 revealed the resident required total assistance with bathing and toileting, physical assist with dressing, walking, and transfers. The resident also could not manage her own medications, was incontinent of bladder, had cognitive impairment, and current problems with falls and inappropriate behaviors. Review of the resident's negotiated service agreement dated 8-26-20 revealed the resident required physical assistance of 1 staff with all activities of daily living except eating which she requires supervision from staff. It also included the same general fall interventions as resident #3, directed staff to redirect the resident when she	S3090		

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S3090	Continued From page 2 wandered, and to monitor/observe for changes in behaviors. Review of the resident's record lacked an initial negotiated service agreement dated on or before 7-22-20, the date of the resident's admission to the facility. On 9-23-20 at 9:55 AM surveyor requested copies of resident #3 and #9's initial negotiated service agreement upon admission. On 9-23-20 at 1:52 PM certified medication aide C confirmed neither resident had an initial admission negotiated service agreement completed upon admission to the facility. The Executive Director failed to ensure the development of an initial negotiated service agreement for 2 (#3 and #9) of 8 sampled residents.	S3090		
S3155 SS=E	26-41-204 (a) Health Care Services (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by:	S3155		

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S3155	Continued From page 3 KAR 26-41-204 (a) The facility reported a census of 33 residents. The sample included 7 residents. Based on interview and record review the Executive Director failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 3 (#3, #5, and #8) of 4 residents sampled who had falls. Findings included: - Review of resident #3's medical record revealed he admitted to the facility on 7-30-20 with diagnoses of diabetes type 2, coronary artery disease, chronic kidney disease, alzheimers disease and chronic obstructive pulmonary disease. Review of the residents functional capacity screen (FCS) dated 8-27-20 revealed the resident required physical assistance with bathing, had bladder incontinence, current problems with falls, wandering and impaired decision-making, and was unable to manage his own medications. Review of the negotiated service agreement (NSA) dated 8-27-20 revealed the facility staff would assist the resident with bathing twice a week, had generalized falls interventions, and identified staff would administer the residents medications 3-4 times per day. The NSA failed to identify services related to bladder incontinence, poor cognition, and wandering. Review of an incident report form completed by certified staff M revealed she found the resident on the floor and notified another medication aide of the fall.	S3155		

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S3155	Continued From page 4 Review of the resident's electronic medical record on 9-22-20 at 9:05 AM revealed the record lacked any nurses notes or evidence a nurse assessed the resident after his fall in order to coordinate cares necessary to meet his needs related to falls risk. - Review of resident #5's medical record residents record revealed the resident admitted to the facility on 1-7-20 with diagnoses of Alzheimers dementia and diabetes type 2. Review of the residents functional capacity screen dated 9-1-20 revealed the resident required physical assistance with bathing, dressing and toileting. The resident also had current problems with falls. Review of the resident's negotiated service agreement dated 3-10-20 revealed 1 staff needed to assist the resident with bathing, dressing and toileting and the resident needed a fall mat on the floor and used a walker. Review of the fall incident report dated 9-3-20 revealed certified staff F completed the incident report, and it revealed she got help from the medication aide who assessed for injuries and then they got the resident up and obtained vital signs. The report revealed certified staff F notified certified staff E of the fall. The investigation section of the report finished 7 days after the fall revealed the resident had multiple falls during the past year. It also revealed that a licensed person was not notified of the fall. The resident's record lacked evidence a nurse assessed the resident after her fall in order to	S3155		

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S3155	Continued From page 5 coordinate cares necessary to meet the residents needs related to risk for falls. - Review of resident #8's medical record revealed the resident admitted to the facility on 1-1-15 with diagnoses of alzheimres dementia, anxiety, hallucinations, pain and dysphagia. The residents functional capacity screen dated 12-9-2019 revealed the resident required physical assistance with activities of daily living except only needed supervision with eating. The functional capacity screen identified the resident did not have current problems with falls. Review of the residents functional capacity screen dated 12-9-19 directed staff to assist the resident with activities of daily living and did not include anything specific related to fall prevention. Review of the paper incident report provided by facility executive director revealed the resident had a fall on 8-11-20 which was completed by certified staff N. The report stated the med aide notified licensed nursing staff O of the fall. Review of the residents medical record included an electronic incident report of an incident on 8-11-20 where the resident fell out of her chair. The incident report was completed by licensed nursing staff L on 8-26-20, 15 days after the fall. It identified licensed nursing staff were not notified at the time of the fall in order to complete an assessment. Review of the resident's record lacked evidence a nurse assessed the resident after her fall in order to coordinate cares necessary to meet the resident's needs related to risk for falls.	S3155		

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S3155	Continued From page 6 During an interview on 9-23-20 at 1:45 PM certified staff P reported if a resident fell the staff are supposed to call someone to come and help. If the nurse is not in the building we are to call the nurse and if they hit their head we automatically send the resident to the local emergency room for evaluation. During an interview on 9-23-20 at 1:50 PM certified staff E stated if the nurse wasn't in the facility or didn't respond to staff phone calls I just had the staff call me and then she would call the family. During an interview on 9-23-20 at 2:15 PM Executive Director A reported if a resident fell staff were to reach out to the nurse in the building or contact certified staff E because "we have had spotty nurse coverage". Review of the information provided by the Executive Director on 9-22-20 revealed the facility didn't have a licensed nurse for staff to contact on the following dates except for the consulting nurse on: August 14-23; August 29-31; September 5-8; September 12-14 and September 18th. Review of the fall response procedures dated 7-15-20 revealed if a resident had a fall, staff would provide immediate care and follow through with service planning. The Executive director failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 3 of 4 residents sampled who had falls	S3155		

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S3200	Continued From page 7	S3200		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 33 residents. The sample included 7 residents. Based on observation, interview and record review the Executive Director failed to ensure 3 (#3, #6, and #7) of 3 residents reviewed for medication administration had all medications and biologicals administered according to a medical care provider's written order and professional standards of practice. Findings included: - Review of resident #3's medical record	S3200		

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S3200	Continued From page 8 revealed he admitted to the facility on 7-30-20 with diagnoses of diabetes type 2, coronary artery disease, chronic kidney disease, alzheimers disease and chronic obstructive pulmonary disease. Review of the residents functional capacity screen (FCS) dated 7-31-20 revealed the resident was unable to manage his own medications. The FCS dated 8-27-20 also revealed the resident could not manage his own medications. Review of the negotiated service agreement dated 8-27-20 revealed facility staff would administer the residents medications 3-4 times per day. Review of the residents record lacked signed admission medication orders but did include a signed physicians progress note dated 8-21-20 with the following history of medication orders: Amlodipine 10 milligrams (mg) daily Atrovastatin 40 mg daily Depakote Sprinkles 125 mg twice a day Flomax 0.4 mg daily Keppra 500 mg twice a day Lisinopril 20 mg daily Imodium twice a day at 9 and 5 Melatonin 3 mg at bed time Metformin 500 mg twice daily Multivitamin daily Zyprexa 2.5 mg daily Protonix 40 mg daily Zolof 50 mg daily Review of the resident's August 2020 medication administration record (MAR) revealed the facility staff failed to administer the following medications according to the physicians orders: The resident did not receive 8 doses of Imodium	S3200		

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S3200	Continued From page 9 (medication for bowels); 19 doses of Multivitamin; 7 doses of Melatonin (for insomnia); 18 doses of Keppra (an anticonvulsant); 9 doses of Zyprexa (and antipsychotic); 5 doses of Amlodipine (for high blood pressure); 3 doses of Zoloft (an antidepressant); and 1 dose of Depakote Sprinkles (an anticonvulsant). Review of the resident's September 2020 MAR revealed the facility staff failed to administer the following medications according to the physicians orders: The resident did not receive 8 doses of Amlodipine; 22 doses of Depakote Sprinkles; 47 doses of Keppra; 18 doses of Lisinopril (for high blood pressure); 26 doses of Metformin (for diabetes); 23 doses of Multivitamin; 19 doses of Protonix; 4 doses of Zyprexa; 23 doses of Zoloft; 2 doses of Atrovastatin, and 2 doses of Flomax. - Review of resident #6's medical record revealed she admitted to the facility on 7-1-16 with diagnoses of depression, glaucoma, pulmonary edema and osteoporosis. Review of the resident's medical record revealed a functional capacity screen dated 1-16-20 which noted the resident could not manage her own medications and medical treatments. Review of the resident's negotiated service agreement dated 1-16-20 revealed facility staff would administer the resident's medications 3-4 times per day. Review of the resident's signed hospital discharge orders included the following medications: Aspirin 81 mg daily Doxazosin 2 mg daily	S3200		

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S3200	Continued From page 10 Losartan 100 mg daily in the morning Polyethylene Glycol 238 GM - 8.5 gm daily as needed Paroxetine 40 mg at bedtime Seroquel 25 mg 0.5 tab at bedtime Simvastatin 10 mg at bedtime Spironolactone 25 mg at bedtime Review of the resident's medication administration record (MAR) for September 2020 revealed the facility staff failed to administer the following medications according to physicians orders: The resident did not receive 3 doses of Aspirin 81 mg; 19 doses of Seroquel (antipsychotic); 18 doses of Simvastatin (for cholesterol); 13 doses of Doxazosin (for high blood pressure); 7 doses of polyethylene Glycol (constipation); 4 doses of Losartan (for high blood pressure); 4 doses of Spironolactone (high blood pressure) and 3 doses of Paroxetine (antidepressant). - Review of resident #7's medical record revealed she admitted to the facility on 6-20-18 with diagnoses of Dementia, Depression and hypothyroidism. Review of the resident's functional capacity screen dated 3-4-20 revealed the resident could not manage her own medications or medical treatments. Review of the resident's negotiated service agreement dated 2-18-20 revealed facility staff would administer the resident her medications 3-4 times per day. Review of the resident's signed physician orders included the following medication orders: 2-21-20 - Acidophilus 500 milligrams (mg) 1	S3200		

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S3200	Continued From page 11 capsule daily 6-4-20 - Seroquel (antipsychotic) - 25 mg 1/2 tablet at bedtime 6-11-20 - Seroquel 25 mg. 1 tablet twice daily 8-21-20 - Alprazolam (anxiety) 0.5 mg daily Review of the residents medication administration (MAR) for August 2020 revealed the staff failed to administer 15 doses of Acidophilus and 6 doses of Seroquel. Review of the resident's September MAR revealed the staff failed to administer 22 doses of Acidophilus; 10 doses of Seroquel at bedtime; 10 doses of Seroquel day doses; and 3 doses of Alprazolam. Review of each resident's (#3, #6, and #7) medical records/nurses notes lacked documentation regarding attempts to contact the pharmacy or the resident's medical provider in order to ensure the resident received medications as ordered. During an interview on 9-21-20 at 4:15 PM certified staff E reported there was a problem with not having medications to administer that are on the resident's MAR. Staff E stated if a medication is not in the cart or overflow they let certified staff C know because she does all the paperwork. Staff E will sometimes call the pharmacy when there are a few pills left otherwise certified staff C takes care of it. Staff E also reported that she was directed to document "awaiting on pharmacy" on the MAR if the medication is not available. During an interview on 9-21-20 at 4:25 PM certified staff F reported the facility had issues with getting medications for residents. Staff F said there is a night staff aide who orders	S3200		

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S3200	Continued From page 12 medication every Wednesday for what doesn't come with the monthly cycle fill. If the medication is not available will chart not available. Staff F reported she will call the pharmacy when it is an "important" medication that is not here. During an interview on 9-22-20 at 1:30 PM certified staff C reported there is an issue with getting medications from the pharmacy timely. If the medication aide cannot find the medication they are supposed to call the pharmacy to see why it is not here. Staff C stated the physicians had not been contacted about the residents not receiving all medications as ordered. During an interview on 9-23-20 at 2:15 PM Executive Director A reported staff needed to alert someone so the nurse practitioner could write new orders if needed. Review of the clinical policy and procedure related to medications revealed under Refills #5. Each shift the Med Aide is to follow through with refills pending (re-fax, call pharmacy, call family, etc.) #6. Should a medication run out, the nurse or Med Aide makes a note in the record recapping any attempts and/or the situation that led to the medication becoming unavailable. The responsible part and physician are contacted. The Executive Director failed to ensure all medications and biologicals were administered to residents according to a medical care provider's written order and professional standards of practice.	S3200		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 13 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 33 residents. The sample included 7 residents, 5 of whom were reviewed for incidents, accidents, or other changes in condition. Based on record review and interview for 4 (#3, #4, #6, #9) of 5 residents the executive director failed to ensure their medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Review of resident #3's medical record revealed he admitted to the facility on 7-30-20 with diagnoses of diabetes type 2, coronary artery disease, chronic kidney disease, alzheimers disease and chronic obstructive pulmonary disease. Review of the residents functional capacity screen (FCS) dated 8-27-20 revealed the resident required physical assistance with bathing, had bladder incontinence, current problems with falls, wandering and impaired decision-making, and was unable to manage his own medications.	S3261		

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S3261	Continued From page 14 Review of the negotiated service agreement (NSA) dated 8-27-20 revealed the facility staff would assist the resident with bathing twice a week, had generalized falls interventions, and identified staff would administer the residents medications 3-4 times per day. The NSA failed to identify services related to bladder incontinence, poor cognition, and wandering. Review of the resident's electronic medical record on 9-22-20 at 9:05 AM revealed the record lacked any nurses notes. Review of the medication aide communication log revealed on 8-17-20 the resident returned from the hospital and on 8-18-20 the resident fell at 12:00 AM. During an interview on 9-21-2020 certified staff E reported when the resident returned from the hospital he was very weak and I believe he fell out of bed the night he got back from the hospital. The resident's record failed to include documentation regarding admission to the facility, documentation regarding the nurse assessment and need for transfer to local hospital, return from the hospital and fail to include documentation regarding the resident's fall, nurse assessment and findings any action taken and results of action. - Review of resident #4's medical record revealed the resident admitted to the facility on 10-24-15 with diagnoses of diabetes type 2, hypertension, osteoarthritis, and pain. Review of the resident's functional capacity screen dated 3-4-20 revealed the resident was	S3261		

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NAME OF PROVIDER OR SUPPLIER BLACKHAWK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 22550 S FRANKLIN STREET SPRING HILL, KS 66083		
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S3261	Continued From page 15 independent with activities of daily living, could not manage her own medications or treatments, had impaired vision and decision-making abilities. Review of the residents negotiated service agreement dated 8-4-20 revealed the facility staff administered the residents medications and prepared the resident's insulin pen for her to be able to self-inject her insulin. Review of the resident's electronic record included an incident report for falls on 6-12-20 and 8-13-20. The resident's record lacked follow up documentation related to skin tears acquired during both falls, action taken to reduce risk of further falls and outcomes of those actions. - Review of resident #6's medical record revealed she admitted to the facility on 7-1-16 with diagnoses of depression, glaucoma, pulmonary edema and osteoporosis. Review of the resident's medical record revealed a functional capacity screen dated 1-16-20 revealed the resident was independent with activities of daily living, had current problems with falls and impaired vision, and could not manage her own medications and medical treatments. Review of the resident's negotiated service agreement dated 1-16-20 revealed facility staff would remind the resident to use her walker and would administer the resident's medications 3-4 times per day. Review of the residents medical record included signed hospital discharge orders dated 9-3-20. Review of the medication aide log revealed on	S3261		

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S3261	Continued From page 16 9-3-20 the resident was back from the hospital. Review of the resident's medical record lacked nursing documentation as to the reason the resident went to the hospital, that she went to the hospital and that she returned from the hospital and follow up after her return. - Review of resident #9's medical record revealed she admitted to the facility on 7-22-20 with diagnoses of anemia, repeated falls, coronary artery disease, reflux disease, dysphagia, and anxiety. Review of the resident's functional capacity screen dated 8-26-20 revealed the resident required total assistance with bathing and toileting, physical assist with dressing, walking, and transfers. The resident also could not manage her own medications, was incontinent of bladder, had cognitive impairment, and current problems with falls and inappropriate behaviors. Review of the resident's negotiated service agreement dated 8-26-20 revealed the resident required physical assistance of 1 staff with all activities of daily living except eating which she requires supervision from staff. It also included the same general fall interventions as resident #3, directed staff to redirect the resident when she wandered, and to monitor/observe for changes in behaviors. Review of the resident's medical record/nurses notes lacked documentation regarding the resident not eating well or her fall, action taken and results of those actions. It also lacked documentation of regarding date, time and reason resident was sent to the hospital in July.	S3261		

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S3261	Continued From page 17 Review of the medication aide communication log revealed the following documentation: 7-28-20 - rolled out of bed onto floor - 12:30 nurse notified; slept all day - temp 99.7; at 8:15 temp 100.1, notified medication aide; running high fever, send to hospital. 8-5,11,12,13,19,-20 all included the resident not eating much 8-27-20 - very weak, not bearing weight During an interview on 9-21-20 at 4:20 PM certified staff E reported the resident needed total assistance of staff, especially in the last week she was in the facility. She was so small I could just cradle her and pick her up. Staff E stated the resident was not a big eater, would take a couple of bites and then spit everything out. During an interview on 9-23-2020 at 2:15 PM executive director A reported she would expect the residents nurses notes to include documentation regarding admission to facility, falls and fall follow up as well as any reasons a resident would be sent to the hospital and information upon their return to the facility. Review of the policy dated 7-15-18 revealed "the resident care director of medication aide, as assigned, documented significant information from the staff's charting on the end of shift report in the resident's record." Review of the Fall response procedures dated 7-15-16 revealed for 48 hours after any fall, the resident care director of medication aide on each shift will monitor the resident and make a brief note in the resident's record. The executive director failed to ensure 4 of 5	S3261		

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S3261	Continued From page 18 residents medical records contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S3261		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident 's food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the	S3305		

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S3305	Continued From page 19 health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b) The facility reported a census of 33 residents. The sample included 7 residents. The administrator failed to ensure the implementation of infection control procedures related to COVID-19 and ensuring all staff completed the screening process for signs/symptoms of COVID-19. This failure had the potential to affect all residents. Findings included: - Review of the facility computerized schedule and employee questionnaires for all departments of the facility for the months of August 2020 and September 2020 included multiple days when staff were to work that did not have a completed questionnaire. Review of certified staff G's actual punch time log revealed she worked 9 days in August and 11 days thus far in September. Review of the employee questionnaires for the month of August and September lacked a completed questionnaire for any of the days staff G worked. Review of certified staff H's actual punch time log revealed she worked 24 days in August and 16 days in September. Review of the employee questionnaires for the months of August and September lacked a completed questionnaire for 6 days in August and 8 days in September that	S3305		

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S3305	Continued From page 20 staff H worked. Review of certified staff I's actual punch time log revealed she worked 17 days in August and 12 days in September. Review of the employee questionnaires for the months of August and September lacked a completed questionnaire for 9 days in August and 11 days in September that staff I worked. During an interview on 9-22-20 at 12:40 PM certified staff C reported all employees were to take their own temperature and answer the questions on the form by the back door when they come into work. Staff C confirmed that certified staff G had tested positive for COVID-19 the first part of August and had worked in the facility since her quarantine at home. During an interview on 9-22-2020 at 12:53 PM administrative staff A confirmed all employees were to complete the COVID-19 questionnaire when they arrive to work for their shift. Review of the facility's Covid-19 policy and procedures dated 8-11-20 on page 10 under the heading Screening of Residents, Staff, and Visitors revealed the following: "1. All persons entering the community should be screened for signs and symptoms or possible exposure to COVID-19... 5. Screening of staff should be at the start of every shift." The Administrator failed to ensure all staff followed procedures according to the facilities infection control policy for COVID-19 by failing to complete the COVID-19 questionnaire upon entering the building for work.	S3305		